

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-045061

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 140

FILED DEC 3 1965

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Louisiana</u>		c. CITY OR TOWN <u>Louisiana</u>	
Length of stay in 1b <u>lifetime</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pike County Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>R.F.D. #2</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Belle</u> Last <u>Love</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1965</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/2/1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (City and state or country) <u>Pike County Mo.</u>	
13a. FATHER'S NAME <u>J.G. Oliver</u>		14. NAME OF HUSBAND OR WIFE <u>Marion D. Love</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		17. INFORMANT Address <u>Cletis Love Louisiana Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Overwhelming pneumonia with pleural effusion,</u>		<u>left 4 wks</u>	
DUE TO (c) <u>Gastro intestinal hemorrhage</u>		<u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of right hip with internal fixation 12/18/64</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>10:00</u> a.m. <u>11/25/65</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u>Louisiana</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>1960</u> , to <u>11/25/65</u> and last saw her/he alive on <u>11/25/65</u> Death occurred at <u>10:00</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Chas H. Lovell</u> M.D.	
22b. ADDRESS <u>Louisiana, Missouri</u>		22c. DATE SIGNED <u>11/26/65</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/27/1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Louisiana Mo.</u>
24. FUNERAL DIRECTOR <u>Sterne Funeral Home Louisiana Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 27, 1965</u> 26. REGISTRAR'S SIGNATURE <u>Bernice Callier</u> <u>H.S.M.C.</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

VS 300  
Rev. 4/59

DATE AMENDED

1 0822

2 0820

3

4 1

5 2

6

7 0

8 0

9578X

10

11

12 1-0

13 2-2

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J. B. Sterne

Licensed Embalmer No. 4039

P. O. Address Louisiana Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.